Integrating Family-based Counseling and Testing in Programs: The Uganda experience

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Outline

- Background
- Current situation
- New Innovative Counseling and testing Strategies
- How each CT strategy has been implemented
- Lessons learnt
- Conclusions

Background of Counseling and testing in Uganda.

- VCT started in the country about 15yrs ago
- UDHS 2002 revealed high unmet demand for VCT in Uganda: 70% wanted to know, only 10% have received VCT, 12-15% in most recent survey 2004,
- Mature, generalized epidemic without “typical” risk groups

Currently Family VCT low

- Most care and treatment programs do not provide VCT to family members
- Adult clinics rarely offer testing for children of patients ;
- pediatric clinics rarely provide testing for parents
- ART and PMTCT programs have had limited success in having sexual partners come to clinic for testing (<10%)
- >95% of family members of TASO clients never had an HIV test

Scale-up Opportunities

- Resources available
- Opportunity to consider public health equity
- Mandate for evidence-based approaches
- New strategies needed

New strategies for HIV testing and counseling

Overall Goal is near to universal access to HIV testing

Expansion of traditional stand-alone VCT services - outreaches

Three new strategies:

- **Family VCT -Testing of family members of persons with HIV**
  - **Home based /Facility based**
- **Routine HIV Testing and Counseling (RCT) in Clinical Settings**
- **100% door-to-door VCT access: District-wide programs**

VCT for Family members of HIV-infected persons

Why VCT for family members

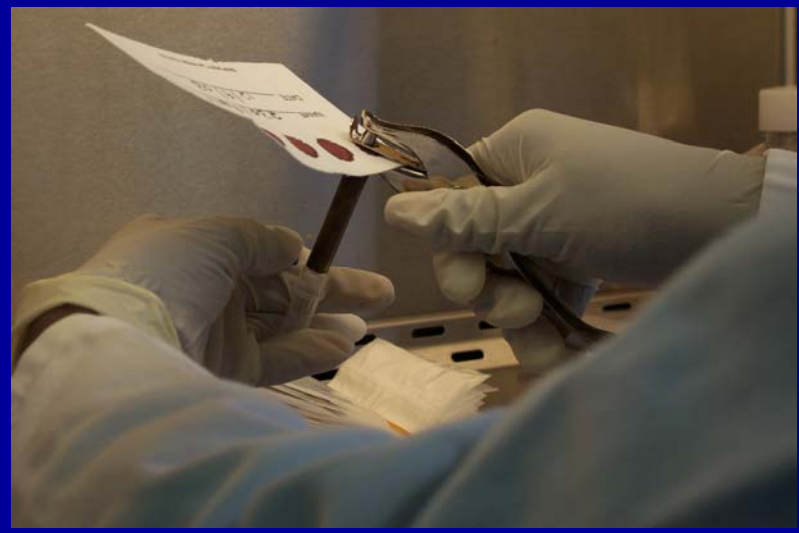
- HIV counseling and testing (VCT) is entry point for prevention, care, & treatment
- Family testing supports family-centered HIV/AIDS services
- Identifies substantial proportion of family that have undiagnosed HIV
- Dramatic improvement in VCT uptake services

Why test family members?

- Reduces disclosure challenges
- Necessary for PMTCT and care for children,
- Critical opportunity for prevention with positives (PWP) programs among discordant couples
- Minimizes pressure for drug sharing
- Allows open household support for cotrimoxazole and ARVs adherence

Home-Based Family VCT (for HH members of HIV-infected patients)

- Home visits scheduled with HIV+ patients
  - Supported disclosure for those who request it
- VCT provided by trained lay counselor
  - Finger stick testing with 3 test algorithm
  - Quality assurance using filter papers



History of home-based VCT in Uganda

Two studies in rural Uganda:

- **Study in Rakai community by UVRI/MOH and MRC showed that**
  - **Providing HIV test results at home had >4-fold increase in VCT compared with offering results at a local clinic**
  - **>25,000 persons provided home-based VCT**

- **Study in Tororo of basic care package showed 97% of 6,000 household members of persons with HIV accepted VCT—99% in their home**

Home based Family VCT in Tororo

- 95% never had a previous HIV test
  - None of 76 HIV-positive children had been previously tested
- 99% accepted VCT at home, average prevelance of 7.5%;
- Of all who tested HIV-positive
  - 74% had never been tested
  - All initiated cotrimoxazole prophylaxis
  - 41% were ART eligible and initiated ART
- 33% of the spouses HIV-ve (Discordance)

Home-based vs. Facility-based approaches for Family VCT

- Randomized evaluation in TASO Jinja
- Free VCT offered to all family members of 500 persons initiating ART
  - Half offered VCT at home
  - Half encouraged to bring family members to facility
- To evaluate coverage and quality of family member in home-based arm versus facility-based arm

Routine Counselling and Testing (RCT) in Clinical Settings

RCT in Mulago and Mbarara Hospitals

- **Mulago and Mbarara are large University teaching hospitals**
  - **Public referral hospitals predominantly serving the poor**
  - **~1 million patient visits per year**

- **Established HIV clinics but services limited**
  - **Free patient HIV testing was not available**

- ***Goal: routine testing of all patients--not diagnostic testing; partner testing; and provision of care and treatment***

RCT Program implementation

- HIV Counseling and testing initiated by the health care providers
- Offered to all patients irrespective of presenting illness

  -Patients with documented results not retested
- Patients reserve the right to opt-out
- Family members of patients also offered testing

RCT Program Implementation

- To date >52,000 people tested over 14 months
- Acceptance of testing >97%
- Prevalence among in-patients: 40-60%
  - Prevalence among spouses: 20-40%
  - 923 couples tested (186 discordant 20%)
- Care referrals for HIV-infected
    - >13,000 HIV+ve patients on cotrimoxazole prophylaxis
    - >70% have CD4 count <200
    - 1,700 PEPFAR ART slots filled; additional 2700 Global Fund slots also filled

100% door-to-door VCT access: District-wide programs

100% VCT access in Bushenyi

- **Implementation by ICOBI (local NGO):**
  - **30 Counsellor/Lab Tech teams**
  - **170 Resident Parish Mobilizers**
  - **Local health center staff trained**

- **Goal: to test >300,000 people of 400,000 adults in district, and children**
  - **Provide basic care and follow-up for HIV-infected -persons and discordant couples**
  - **ART referral dependent on availability**

100% VCT access in Bushenyi

- 130,539 people eligible in 1st 12 months
- 111,697 (90%) at home and counseled
- 109,046 (98%) people accepted testing
- Overall Adult Prevalence: 6%
- Quality Assurance for HIV testing 99% concordant with the CDC ref. lab
- >6190 newly diagnosed HIV-infected persons receiving basic care
  - ~1300 receiving ART at referral sites

Lessons learnt from the three Strategies

- Feasible and highly acceptable
- Demand for testing is high
- Adequate and regular supply of test kits is crucial for program success
- Increased awareness of program eases counseling process
- Infected family members identified early and benefit from Care/ART
- Shared confidentiality with attending personnel was acceptable to patients

Lessons learnt from the three Strategies

- Related HIV/AIDS services complement the CT programs

- Large numbers of newly identified and referred HIV infected persons can overwhelm the already weak health care delivery system.

Conclusions

- Targeted evaluations and pilot programs critical for enabling scale-up of evidence-based programs
- Need leadership and guidelines for an integrating C & T in prevention, care and treatment services
- Consolidation of integration of prevention, care and treatment services.
- New and re-energized prevention agenda needed

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TOGETHER WE CONTINUE TO FIGHT HIV/AIDS